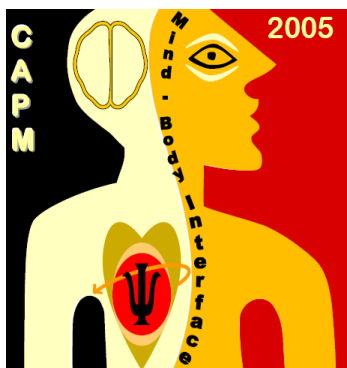


# CAPM Newsletter



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## Submitted CAPM CME Events for 2009 CPA

- Agitation in the Medically Ill: EToh Withdrawal and Secondary Mania. Drs. Hewko and Cook
- Alleviating the Burden in Transition to Adult Care for Adolescents with Chronic Medical Disease. Drs. Brager, Geist, Granich, Russell

## Call for an Organizational Name Change: From Psychosomatic Medicine to Consultation-Liaison Psychiatry

The recent CPA meeting in Vancouver had a strong CAPM presence, including an "oversold" Consult-Liaison Psychiatry update course which was well-received, and likely will be run again at CPA 2010. The AGM had a strong turnout and amongst various topics, there was a discussion around a change in the name of CAPM which would better define us to colleagues, both within and outside of Psychiatry. It was pointed out that the name should represent what most members define themselves as doing and are passionate about. While the field of Psychosomatic Medicine is an established academic pursuit, most members work in the

narrower field of CL Psychiatry, and we are identified by colleagues as subspecialists who train residents in their now mandatory 3 month rotation in CL Psychiatry. CL psychiatrists consider the psychosomatic manifestations of disease but are also adept at managing those with psychiatric conditions who then develop medical illness (eg: MI patient with Schizophrenia or a Demented patient developing an infection), as well as capacity issues which are not specifically related to psychosomatic issues. The liaison role is also an important strength which may distinguish us from other specialists, as we advocate for our patients in

a medical or surgical setting.

The names that were suggested include 'Psychiatry of the Medically Ill' (retain the CAPM acronym and the logo) or 'Medical Psychiatry' (CAMP). Another name is the Canadian Academy of Consultation-Liaison Psychiatry (CACLP). The next step is to move forward within the Board to implement such a change, assuming the general members feel likewise. It could be helpful in the upcoming Royal College re-application process for subspecialty status, which now combines both parts in the initial application. Please email comments to me around this issue. PC

## CAPM Distinguished Member: Dr. Gary Rodin

Dr. Gary Rodin holds a Joint University of Toronto/University Health Network Chair in Psychosocial Oncology and Palliative Care and is Head of the Department of Psychosocial Oncology and Palliative Care

at Princess Margaret Hospital in Toronto. Dr. Rodin is a Professor of Psychiatry and has authored texts on Depression in the Medically Ill, and the Psychiatric Aspects of Transplantation. He is currently leading re-

search on the psychological impact of advanced and terminal disease in affected patients and their families. He is a pioneer of CL Psychiatry in Canada. He was recognized for his enduring work by CAPM in 2008.



## UBC Consultation-Liaison Program and the St. Paul's Hospital Service

The Program of Consultation-Liaison is an Academic and Clinical Program created in 2007. Within the Dept. of UBC Psychiatry, there are no formal divisions now, just programs. Our program aims to promote excellence in teaching in CL Psychiatry at both clinical and academic levels at the various hospitals, and to encourage research. We have members who subspecialize also in Child and Geriatric Psychiatry. Three of our members are on the CAPM Board. Our Program members

meet quarterly for an evening Journal Club or Special presentation. We encourage trainees with an interest in CL Psychiatry to spend elective time with us and we recently have a research track resident joining us who is keen on a project on the EEG manifestations of De-



lirium. We hope to be able to offer Fellowship Training soon. The UBC program director is Dr. Stephen Fitzpatrick, St. Paul's Hospital, 1081 Burrard St., Vancouver, BC. 604-682-2344. Other members in the St. Paul's Hospital CL service are Dr. Carole Richford (Head), Drs. Corral and Raudzus (Adult), Drs. Chauhan and More (Geriatric), and Ms. Karen Malfesi-Merritt, nurse specialist. SJF

## To CAM or not to CAM: Identifying Delirium—Dr. Peter Chan

Numerous publications have described the under-recognition of Delirium, particularly the apathetic subtype, as leading to morbidity and mortality. The most recognized screening tool is the Confusion Assessment Method (CAM), and there is one adapted for the ICU. The CAM surveys symptoms of delirium as per DSM IV, was developed and tested in acute care settings, has been shown to have excellent sensitivity and specificity rates (generally over 90%), and is quick to administer. The CAM includes a standardized algorithm for identifying individuals with probable delirium (acuteness of onset & variable course, inattention, disorganized thinking and altered level of consciousness). According to an evidence-based review in the national guidelines in managing geriatric delirium (2006), the CAM is recommended for screening, assessment/diagnosis of delirium

in seniors in medical/surgical acute care, ER and cardiac surgery (Level IIa, III). However, there are practical and logistical issues in using the CAM, which is mainly designed for front-line nurses to screen for delirium, triggering a referral to a physician when the screen is positive. Nursing staff work in shifts, and may not appreciate documenting core symptoms over a 24 hour period, as many chart based on their observation in their 8-12 hour shift. This will potentially miss the fluctuating nature of Delirium. Those with advanced Dementia may appear to fluctuate by 'sundowning' upon hospitalization, making it difficult to distinguish from Delirium sometimes. Identifying the delirium and informing the physician may lead to no further action, as the attending physician may under-recognize the urgency in managing the Delirium medically and psychiatrically.

### 'Geriatric Delirium Management

**Guidelines' Canadian Coalition for Seniors' Mental Health. 2006.**

**Website: [www.ccsmh.ca](http://www.ccsmh.ca)**

**Click 'guidelines' tab and it can be downloaded free of charge.**

Educating health professionals in this regard is of course helpful, particularly in units with high staff turnover (eg: teaching units). Gaining collateral information is essential in cases where Dementia and Delirium are comorbidities. A protocol to use the CAM can only be effective if there is a systematic way to trigger further management; otherwise, nursing staff will give up. The protocol should consider a referral to CL Psychiatry. In conclusion, the CAM is a useful tool and worth implementing as long as the limitations are known.

## St. Paul's Hospital LAKD Program: Transplanting Goodwill-Dr. C. Richford

A year ago, the Psychiatry Consultation-Liaison service was approached by the Head of the Renal Transplant service to become part of an interesting new program. The Living Anonymous Kidney Donor (LAKD) program had quietly come out of conception and into practice and Psychiatry was deemed an essential player on the team. The LAKD program involves healthy adults anonymously donating one kidney to help a recipient in need. As we know, the availability of donors for all organs has significantly decreased and the number of people waiting on transplant lists are ever

growing. Many renal patients waiting for kidneys do not have any suitable relative donors and are faced with cadaveric transplants or a lifetime of dialysis. Psychiatry is identified as a key player in this program. As this program has the potential to be controversial, the Nephrologists have made the requirement of mandatory Psychiatric assessment by our service and that we have full veto to exclude a candidate from potential donation. This is to try to ensure the safety of the donor's psychological state and to ensure that the LAKD program does not receive negative scrutiny. In our experience with this

program, we have come to find that there are certain people who operate from altruism. It is rare but exists!! This has been heart-warming. Other people have come to the program with an agenda that has seen them rejected. The motivation has been varied but has included one who wanted to impress her significant other and one with significant psychopathy and wanted to get some mileage from his apparent goodwill. It is our vision to continue this liaison with the Renal Transplant service and to work together to help this program develop, as many programs in Europe have been successful. CR

## CIWA "Protocol" for Alcohol Withdrawal in a General Hospital Setting: Cautionary notes from CL Psychiatry experience —Dr. Robert Hewko, MD, FRCPC. Clinical Professor, UBC.

While a growing body of literature supports the use of the CIWA as a tool to symptomatically manage alcohol withdrawal, what we, at the CL Psychiatry Service at Vancouver General Hospital, are increasingly being asked to treat are the negative consequences of such unfocused, protocol-driven care. The core problem is that the CIWA (Clinical Instrument Withdrawal Assessment), now used in pre-printed order form to manage alcohol withdrawal in medical/surgical pa-

tients, was developed in a hospital detox setting, making it a seriously flawed instrument if used indiscriminately in medically compromised patients; the items used to score the severity of withdrawal and subsequent management with benzodiazepines cannot differentiate between

symptoms arising from alcohol withdrawal versus other medical issues. In the medically compromised patient the nine scoring items: nausea/vomiting; headache; tremor; diapho-

**Hecksel et al. Inappropriate use of symptom-triggered therapy for alcohol withdrawal in the general hospital.**

**Mayo Clin Proc. 2008 Mar;83(3):274-9**

resis; anxiety; auditory, visual, tactile hallucinations; confusion) only too frequently are the result of other aetiologies. To illustrate: a recent patient, managed with the CIWA protocol, was referred to us for management of refractory alcohol withdrawal. In spite of aggressive management with benzodiazepines the patient continued to run a score above 30, which constitutes "severe" withdrawal on the

CIWA. Our assessment subsequently determined that the patient had a minimal history of alcohol use and was, in fact, experiencing delirium secondary to morphine – not to mention benzodiazepine intoxication. We are seeing multiple variations on this theme as the use of the CIWA further penetrates the general hospital setting. Even more basic problems relating to the use of this instrument are

highlighted in a 2008 article in the Mayo Clinic Proceedings (Hecksel). In light of this as well as other challenges in managing alcohol withdrawal in medically compromised patients, we are planning to present a symposium on this topic at the CPA in Newfoundland later this year. RH

## **2008-2009 CAPM EXECUTIVE and BOARD MEMBERS**

Dr. Peter Chan, President  
Dr. Susan Abbey, Vice-President and President-Elect  
Dr. Fabien Gagnon, Immediate Past President  
Dr. Louis vanZyl, Secretary-Treasurer and Past President

Dr. Stephen Fitzpatrick, BC Board Member  
Dr. Nathan Schaffer, BC Board Member  
Dr. Nancy Brager, AB Board Member  
Dr. Glendon Tait, ON Member-in-Training Member  
Dr. Annette Granich, QC Board Member  
Dr. Marie-Josée Brouillette, QC Board Member  
Dr. Karl Looper, QC Board Member  
Dr. Mark Bosma, NS Board Member

CAPM (Canadian Academy of Psychosomatic Medicine). is one of the 4 recognized academies by the CPA and comprises mostly of hospital-based Consultation-Liaison psychiatrists across the country. It was founded in 2005. One of its major objectives is working with academic institutions to develop, implement and evaluate standards of training for undergraduates, postgraduates, and psychiatrists in the field of Psychosomatic Medicine.

Membership is \$75 annually. Free for members-in-training

Please join us today!

Email for application: [pechan@interchange.ubc.ca](mailto:pechan@interchange.ubc.ca)

## **UPCOMING PSYCHOSOMATIC MEDICINE CME EVENTS**

**ICPM 20TH WORLD CONGRESS. TURIN, ITALY. SEPTEMBER 23-26, 2009**

**ACADEMY OF PSYCHOSOMATIC MEDICINE, LAS VEGAS, NV, NOVEMBER 11-14, 2009**

**CANADIAN PSYCHIATRIC ASSOCIATION MEETING, ST. JOHN'S, NFLD. AUG 27-30, 2009**

**AMERICAN PSYCHOSOMATIC SOCIETY 67TH ANNUAL MEETING, CHICAGO, ILLINOIS. MARCH 4-7, 2009**

## **VGH Consultation-Liaison Psychiatry Service, UBC**

Vancouver General Hospital (VGH) is Western Canada's largest hospital and a major tertiary care centre; it has a large Psychiatry department with 75 onsite inpatient psychiatry beds. The C-L program has been in existence for over 30 yrs and currently has 12 psychiatrists affiliated with it. It is headed by Dr. Robert Hewko who has over 20 years C-L experience, and considerably raised the profile of Psychiatry amongst our specialty colleagues through his dedication and expertise. He has developed a special interest in the management of delirium with Loxapine and other agents, pain,

and alcohol withdrawal. He is often sought out in dealing with challenging patients who have a somatoform or factitious disorder. The inpatient C-L team is extensively involved in undergraduate and postgraduate teaching including junior Surgery, Orthopaedic, and Neurology resident training. Other members of the diverse C-L team are Drs. John Whelan (one of the founding members of the team), Stephen Anderson (burns and trauma), Elaine Drysdale/Andrea Grabovac (psycho-oncology), Nathan Schaffer (chronic care patients), Peter Chan/Ren Persaud/Margo Genge (elder care), Shao-

Hua Lu (concurrent disorders), Sheila Shoja. Dr. Aubrey Axler consults to the outpatient cardiac rehab unit. Our program is fairly well utilized with an average of about 180 consults per month. Early referrals of at risk patients are encouraged as we prefer to put out small blazes rather than infernos. Over the years there have been many challenges both clinically and administratively but these have overcome by the efforts and commitment of our members, and of course, a bit of Loxapine when needed. Those interested can contact Dr. Hewko, former CAPM board member, at VGH, 604-875-4809. NS